October 1996, Vol. 30, No. 8

# *Focus . . . Family Planning in Missouri*

*Introduction: Need for Family Planning Services*

Unintended pregnancy, especially unintended childbearing, has important consequences not only for the individuals involved but also for the society as a whole. The individual woman may face decreased life opportunities and/or economic hardship as a result of an unintended pregnancy. In addition, higher rates of poor outcomes (low birth weight, infant mortality) and poor prenatal behavior (inadequate prenatal care and substance abuse) are associated with unintended pregnancies.

Unintended pregnancies accounted for over half (57.3 percent) of all pregnancies in the United States in 1987. Half of these unintended pregnancies end in induced terminations and half result in live births. The proportion of births resulting from unintended pregnancies increased from 37 percent in 1982 to 44 percent in 1990. In Missouri the proportion of births resulting from unintended pregnancies may be even higher.

Provision of family planning services to women at risk of unintended pregnancy thus becomes of vital importance. Missouri is close to the national estimated rate for both the percentages of all women age (13-44) at risk of unintended pregnancy (48.4 Missouri, 49.4 United States) and of all women in need of organized or subsidized contraceptive services (25.6 Missouri, 24.4 U.S.). In this report we look at family planning data reported by clinics funded through state general revenue (GR) funds and many clinics funded by Title V. Because of shortfalls in data completeness, minorities, who mostly reside in Missouri's major cities, are under represented in this file.

Description of GR/Title V Family Planning Clientele

From July 1994 through June 1995, 18,464 females made an initial or annual visit to a family planning clinic. Of these, nearly 7,000 were initial visits. Although all women with unimpaired fertility are at risk of unintended pregnancy, incidence is higher among certain groups of women. Females at either end of the reproductive age spectrum (<20 or >39), unmarried women, and poor women have higher rates of unintended pregnancy than do women 20-39 years of age, married women and women with incomes greater than 200 percent of the poverty level. Table 1 presents the demographics of the clientele utilizing family planning services.

An examination of the data reveals that those females making an initial visit to a family planning clinic are more likely to fall into those groups most at risk of an unintended pregnancy. As Table 1 indicates the clientele making an initial visit to a family planning clinic are younger, less educated and more likely to be unmarried than are women making an annual visit. Concomitant with these characteristics of youth, unmarried and low education, 41 percent of the clientele at an initial visit have incomes at or below 100 percent of the federal poverty level compared to slightly less than 34 percent at annual visits

There are differences in service characteristics by type of visit. A higher percentage of women making an annual visit to a family planning clinic chose one of the more effective (prescription-based) contraceptives than did women making an initial visit. After the age of 35 the use of less effective over-the-counter contraceptive methods reflects the lower risks as fertility decreases. Among women age 40 or over nearly a third have chosen sterilization either of self or partner as a means of contraception.

Higher rates of choosing one of the more effective prescription-based methods are found among clients who are currently students, not married and white. Poverty status most clearly related to the choice of the less effective over-the-counter contraceptives with clients closest to the poverty level being more likely to choose an over-the-counter method. Poverty status may also help explain the different pattern of contraceptive choice by African Americans and whites. African Americans are more likely than are whites to use no method of contraception or to use a less effective over-the-counter method or sterilization.

High-Risk Group

Public family planning services are set up to address the fertility needs of all women in the fertility range. However, women having one or more of the above noted high-risk factors accounted for 81.8 percent of all initial visits, 71.6 percent of all annual visits and 75.4 percent of total family planning visits. This indicates that the services are being utilized by those most at-risk of an unintended pregnancy. *3

Among the high-risk group, 70 percent are using the birth control pill as their primary means of contracepting with usage of Depo Provera by 13.5 percent, condoms by 5.2 percent and sterilization by 3.6 percent. A further breakdown indicates that among those most likely to choose the birth control pill are teenagers (76.7 percent) and never-married women (74.7 percent). Women 39 or older (24.3 percent) and non-teenaged women with less than a high school education (60.4 percent) are among those least likely to use birth control pills and most likely to use condoms or sterilization as their primary means of contraception. Women below the poverty level are the most likely high-risk group to report using Depo Provera (15.5 percent) closely followed by teenagers (14.9 percent).

Initial visit high-risk clients were more apt to use Depo Provera as their primary method of birth control than are women making annual visits with 15.8 percent and 12.0 percent reported respectively. This higher usage of Depo Provera at initial visit than annual visit is the case for all the categories that make up the high-risk group. Depo Provera is less client dependent than most other methods of contracepting which may make it more suitable for these clients.

Of all clients making an initial or annual visit to a family planning clinic, approximately 12 percent (2,213) had been pregnant in the twelve months preceding the visit. Of these pregnancies, 32 percent were intended and 55 percent were unintended with pregnancy intention unknown for the remaining pregnancies. Clients making an initial visit to a family planning clinic had a higher rate of unintended pregnancy than did clients making an annual visit. Nearly two-thirds of the clients with a pregnancy during the previous twelve months were making an initial visit to the clinic. Figure 1 presents a breakdown by type of visit and intentionality for those clients with a pregnancy within the past year. As Figure 1 indicates not only did those women making an initial visit have more pregnancies but also more of these pregnancies were unintended than were those of the women making an annual visit. Nevertheless, it is important to note that the majority of pregnancies were unintended even for those making an annual visit. Women making an initial visit to a family planning clinic had a much higher rate of pregnancy (200.0 per 1,000 females) than did women making an annual visit. This latter rate (73.1) was close to the overall state rate of 74.4 pregnancies per thousand females.

*Contraceptive Practice Change and Pregnancies Averted*

A measure of family planning impact is change in contraceptive practice. Accordingly, the contraceptive methods used by the client before and after the visit are compared in Table 2. Of all clients making an initial or annual visit nearly 2,000 were not using any method of contraception prior to the visit. Nearly 75 percent of these clients began using a prescription-based method and an additional 6 percent began using an over-the-counter method. Also, of those clients making an initial or annual visit with prior use of an over-the-counter method, over 75 percent changed to a prescription-based method. Clients who had been pregnant within the past year and had not been using a contraceptive were even more likely to adopt a prescription-based method (81.2 percent). Ninety percent of all clients chose one of the more-effective (prescription-based) methods as their contraceptive following the family planning visit.

It is estimated that "For every 1,000 women using reversible contraceptives and relying on a publicly funded provider, 260 unintended pregnancies are prevented, including 112 live births and 114 induced abortions with the remainder spontaneous abortions and stillbirths". Of the 18,464 females who utilized family planning clinics either for an initial

or annual visit, 90.4 percent (16,689) were using a reversible contraceptive method after the visit. Applying this estimate to the 16,689 results in 4,339 averted pregnancies including 1,869 live births, 1,903 induced abortions and 567 spontaneous abortions and stillbirths

*Conclusion*

The chief measure of a program's effectiveness is whether it accomplishes stated goals. Despite the limited data available, it appears that the family planning program is meeting the goal of enabling women to better control their fertility through averting and/or delaying pregnancy. Decreases in abortions and in births occurring to women within 18 months of a previous birth suggest that some unintended pregnancies are being avoided. Most clients leave a family planning visit practicing some form of contraceptive and usually a more effective method than they were using prior to the visit.

An important part of the current effort in family planning is to provide services to those most in need of help in controlling their fertility. The overwhelming proportion of females utilizing public family planning services are the most at-risk for unintended pregnancy and therefore, the ones most in need of these services. The need for family planning services will not only not decrease in the immediate future but as the fertile range becomes more weighted toward the younger age groups may actually increase due to both their higher level of fertility and increased risk of unintended pregnancy.

Footnotes:

1* The NICHD/Missouri Maternal and Infant Health Survey - a case-control study of women who gave birth between December 1, 1989 and March 31,1991 found that over 50 percent of all births were unintended (Sable, et al., in press).

2* Title V clinics in St. Louis City, St. Louis County and Kansas City only furnished aggregate data for fiscal year 1995 but will be providing individual data beginning in fiscal year 1996. Also, this file does not contain client data for other publicly funded family planning sources (e.g., Medicaid, Title X, Federal 330 and 329 clinics).

3* If complete data were available for all served by public Family Planning Programs (including Medicaid) by county we could potentially come up with an indicator of met-need. An example: (# women served less than 150% poverty level/# of women in the in-need population)*100.

**Table 1**

**Family Planning Female Clients Selected Characteristics by Type of Visit**

**Missouri General Revenue and Incomplete Title V**

**Fiscal Year 1995**

| | *Visit* | | | | | |
|---|---|---|---|---|---|---|
| | *Initial* | | *Annual* | | *Total* | |
| | *Number* | *Percent* | *Number* | *Percent* | *Number* | *Percent* |
| Total | 6,804 | 100.0 | 11,660 | 100.0 | 18,464 | 100.0 |
| *Age* | | | | | | |
| <20 | 2,717 | 39.9 | 2,457 | 21.1 | 5,084 | 27.5 |
| 20-24 | 1,791 | 26.3 | 3,415 | 29.3 | 5,206 | 28.2 |
| 25-29 | 966 | 14.2 | 2,367 | 20.3 | 3,333 | 18.0 |
| 30-34 | 650 | 9.6 | 1,914 | 16.4 | 2,564 | 13.9 |
| 35-39 | 323 | 4.8 | 887 | 7.6 | 1,210 | 6.6 |
| 40-50 | 196 | 2.9 | 352 | 3.0 | 548 | 3.0 |
| *Education* | | | | | | |
| <12 | 2,382 | 35.0 | 2,375 | 20.4 | 4,757 | 25.8 |
| 12 | 2,734 | 40.2 | 6,052 | 51.9 | 8,786 | 47.6 |
| 13-17 | 1,093 | 16.1 | 2,356 | 20.2 | 3,449 | 18.7 |
| *Current Student* | | | | | | |
| Yes | 2,207 | 32.4 | 2,491 | 21.4 | 4,698 | 25.4 |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Race* | | | | | | |
| White | 6,055 | 89.0 | 10,348 | 88.7 | 16,403 | 88.8 |
| Black | 604 | 8.9 | 1,205 | 10.3 | 1,809 | 9.8 |
| All other | 145 | 2.1 | 107 | 0.9 | 252 | 1.4 |
| *Marital Status* | | | | | | |
| Married | 1,999 | 29.4 | 4,548 | 39.0 | 6,547 | 35.5 |
| Never Married | 4,031 | 59.2 | 5,723 | 49.1 | 9,754 | 52.8 |
| Formerly Married | 774 | 11.4 | 1,389 | 11.9 | 2,163 | 11.7 |
| *Poverty Status* | | | | | | |
| <=100% | 2,815 | 41.4 | 3,938 | 33.8 | 6,753 | 36.6 |
| 101-150% | 1,614 | 23.7 | 3,539 | 30.3 | 5,153 | 27.9 |
| 151-250% | 695 | 10.2 | 1,667 | 14.3 | 2,362 | 12.8 |
| >250% | 866 | 12.7 | 1,262 | 10.8 | 2,128 | 11.5 |

**Table 2**

**Missouri Family Planning Clients Annual and Initial Visits Contraceptive Effectiveness by Visit**

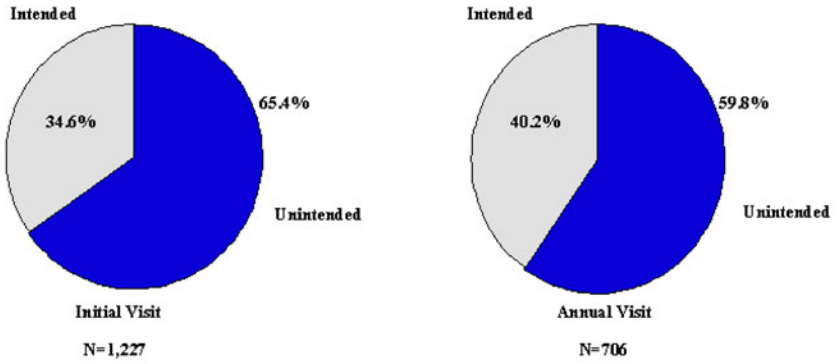
**Missouri Fiscal Year 1995**

| *Method Prior to Family Planning Visit* | | *Method Following Visit* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | *No Method* | | *Over-the-Counter Method* | | *Prescription Based Method* | | *Sterilization* | |
| | *Total Number* | *Number* | *Percent* | *Number* | *Percent* | *Number* | *Percent* | *Number* | *Percent* |
| No Method* | 1,683 | 331 | 19.7 | 108 | 6.4 | 1,242 | 73.7 | 2 | 0.1 |
| Over-the-Counter** | 4,168 | 41 | 1.0 | 930 | 22.3 | 3,191 | 76.5 | 6 | 0.1 |
| Prescription-Based*** | 11,327 | 64 | 0.6 | 118 | 1.0 | 11,133 | 98.2 | 12 | 0.1 |
| Total | 17,178 | 436 | 2.5 | 1,156 | 6.7 | 15,566 | 90.6 | 20 | 0.1 |

* Excluding those pregnant or seeking pregnancy.
** Over-the-Counter methods include abstinence, natural family planning, withdrawal, condom, condom with spermicide, contraceptive foam, jelly or cream and contraceptive sponge.
*** Prescription-Based methods include oral contraceptive, cervical cap, IUD, Depo Provera, Norplant and diaphragm.

Figure 1
INTENTIONALITY OF PREGNANCY

*Clients Pregnant Within Past Year Missouri GR and Partial Title V - FY 95*




**Provisional Vital Statistics for August 1996**

**Live births** decreased in August as 5,920 Missouri babies were born compared with 7,179 in August 1995. The birth rate decreased from 16.0 to 14.0 per 1,000 population.

**Cumulative births** also show decreases for the 8- and 12-month periods ending with August. For the 12 months ending with August, 72,794 Missouri babies were born compared with 74,803 one year earlier.

The **Natural increase** for Missouri in August was 2,174 (5,920 births minus 3,746 deaths). The rate of natural increase is down for all three periods shown below.

**Deaths** decreased in August, but show virtually no change for the 8- and 12-month periods ending with August.

**Marriages** decreased slightly for all three time periods shown below, while **dissolutions of marriage** increased for all three time periods. The marriage to divorce ratio for the 12 months ending with August decreased from 1.74 in 1995 to 1.67 in 1996.

The **infant death** rate increased slightly in August, but continued to show decreases for the 8- and 12-month periods ending with August. For the first two-thirds of the year the infant death rate decreased from 7.6 to 7.3 per 1,000 live births.

**PROVISIONAL RESIDENT VITAL STATISTICS FOR THE STATE OF MISSOURI**

| Item | August | | | | Jan.- August cumulative | | | | 12 months ending with August | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | | Rate* | | Number | | Rate* | | Number | | | Rate* | |
| | 1995 | 1996 | 1995 | 1996 | 1995 | 1996 | 1995 | 1996 | 1995 | 1996 | 1994 | 1995 | 1996 |
| **Live Births** | 7,179 | 5,920 | 16.0 | 14.0 | 49,625 | 48,844 | 14.0 | 13.8 | 74,803 | 72,794 | 14.3 | 14.1 | 13.6 |
| **Deaths** | 4,311 | 3,746 | 9.6 | 8.8 | 36,570 | 36,577 | 10.3 | 10.3 | 53,803 | 53,876 | 10.3 | 10.1 | 10.1 |
| **Natural increase** | 2,868 | 2,174 | 6.4 | 5.1 | 13,055 | 12,267 | 3.7 | 3.5 | 21,000 | 18,918 | 4.0 | 4.0 | 3.5 |
| **Marriages** | 4,231 | 3,948 | 9.4 | 9.3 | 29,765 | 29,632 | 8.4 | 8.4 | 44,995 | 44,924 | 8.5 | 8.5 | 8.4 |
| **Dissolutions** | 2,236 | 2,255 | 5.0 | 5.3 | 17,212 | 18,322 | 4.8 | 5.2 | 25,835 | 26,836 | 5.1 | 4.9 | 5.0 |
| **Infant deaths** | 42 | 38 | 5.9 | 6.2 | 378 | 361 | 7.6 | 7.3 | 582 | 536 | 7.9 | 7.8 | 7.4 |
| **Population base (in thousands)** | ... | ... | 5,324 | 5,352 | ... | ... | 5,324 | 5,352 | ... | ... | 5,263 | 5,308 | 5,342 |

*Rates for live births, deaths, natural increase, marriages and dissolutions are computed on the number per 1000 estimated population. The infant death rate is based on the number of infant deaths per 1000 live births. Rates are adjusted to account for varying lengths of monthly reporting periods.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER Services provided on a nondiscriminatory basis.

Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health, Center for Health Information Management & Epidemiology/Bureau of Health Data Analysis, P.O. Box 570, Jefferson City, MO 65102; phone (573) 751-6278. Hearing impaired citizens telephone 1-800-735-2966.